DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445013	A. BUILDING _____ B. WING _____	11/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, CHATTANOOGA	2700 PARKWOOD AVE CHATTANOOGA, TN 37404

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F 000	INITIAL COMMENTS Amended Statement of Deficiencies FORM CMS-2567	F 000	This Plan of Correction is submitted as required under State and Federal Law. The submission of this plan does not constitute an admission on the part of NHC HealthCare, Chattanooga as to the accuracy of the Surveyors' findings nor the conclusions drawn therefrom. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	F 157 SS=D See next page...	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

12/17/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to notify the family of an appointment for one resident (#307) and failed to notify the family after a fall for one resident (#236) of three residents reviewed for accidents of forty three residents reviewed. The findings included: Resident #307 was admitted to the facility on October 19, 2012, with diagnoses including Post Surgical Wound to Left 2nd Toe, Dementia with Behaviors, Cardiac Arrhythmia, Pacemaker, Coronary Artery Disease, Hypertension and Hematuria (blood in the urine). Medical record review of a physician's order, dated November 2, 2012, revealed "... (3) Referral to urology..." Medical review of a physician's order November 15, 2012, revealed "...obtain Nephrologists...dx (diagnosis) Persistent Hematuria, Chronic Renal Disease..." Review of the appointment log book revealed on November 6, 2012, an apppointment with a urologist was made for November 14, 2012, at 12:45 p.m. Interview on November 13, 2012, at 4:49 p.m., in the resident's room, with the resident's Power of Attorney (POA) revealed the resident was scheduled for an appointment with the urologist on November 14, 2012. Continued interview revealed "...was not notified of the appointment	F 157	F157 Corrective Action: 1. Resident #307 family was aware of the appointment on 11/13/12 as detailed in the findings. To be completed by: 2. Resident #236 is responsible for herself. She is alert and oriented, makes her own decisions and responsible for herself. She was aware of the incident and interventions explained to her the day of the incident. Other family members who support her were not called. 3) Licensed Nurses will be reinserviced by DON or ADM to contact family members timely when appointments are scheduled & incidents happen. If family members are unreachable, to document attempts made. Identifying Other Patients: 1. To identify any other Residents, all incidents from 11/13/12 to 11/16/12 were reviewed by ADON and no other Residents were affected. 2. To identify any other Residents, all appointments from 11/13/12 to 11/16/12 were reviewed by ADON and no other Residents were affected. Measures & Changes to be taken: 1. All Licensed Nurses will be reinserviced by DON or ADM to contact family members timely when appointments are scheduled and incidents happen. If family members are unreachable, to document attempts made.	11/13/12 11/13/12 12/30/12 12/15/12 12/15/12 12/30/12

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F 157	Continued From page 2 until today (one day before the appointment and if...had not came to visit today...would have never known about the appointment... " Interview with the 100 Wing Unit Manager on November 14, 2012, at 3:45 p.m., in the nurses station, revealed the appointment was made on November 6, 2012, for November 14, 2012 at 12:45 p.m. Continued interview confirmed, "...we usually call the family and let them know and we failed to notify the POA...spoke with the POA yesterday and told...this was an oversight...another nurse made the appointment and the nurse failed to call the POA..." Resident #236 was admitted to the facility on January 21, 2012, with diagnoses including Acute Kidney Failure, Pneumonia, Diabetes Mellitus Type 2, Anxiety, Anemia, Hypertension, Asthma, Coronary Artery Disease, and Chronic Obstructive Pulmonary Disease (COPD). Medical record review of a nurse's note dated November 13, 2012, revealed "...resident found on knee kneeling at bedside facing bed with no apparent injury noted..." Medical record review of the Nursing Care Plan dated November 13, 2012, revealed "...at risk for falls r/t (related to) fracture and anxiety...ensure call light within reach, scoop mattress (7/24/12), ghost alarm and bed alarm..." Review of the Post Fall Nursing Assessment, dated November 13, 2012, revealed "...patient was on knee kneeling at bedside facing bed...then patient turned over onto mat...Family Notified: No..."	F 157	F157 Continued: Monitoring Performance: 1. The DON or ADON will do a QA Study monthly x 2 on 10+ Residents that will include a record review of incidents to ensure family members were notified timely of any incident. It will also include a review of appointments to ensure family members were notified timely of appointments scheduled. Results will be reported monthly to the QA Committee consisting of Medical Director or Physician Designee, DON or Designee, ADM or Asst ADM, SW, Dietician and other team members. After initial 2 month monitoring, QA frequency may be reduced depending on results. To be completed by: (see next page)	12/30/12

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F 157	Continued From page 3 Observation on November 14, 2012, at 4:20 p.m., in the resident's room, revealed the resident lying on the bed, falls mat in place, and a scoop mattress in place. Interview with Licensed Practical Nurse (LPN) #3 on November 14, 2012, at 4:11 p.m., at the 100 Wing nurses station, confirmed "...resident rolled out of the bed on November 13, 2012, was found on...knees on the falls mat...we call the family after any incident..." Interview with the Resident Care Coordinator (RCC) on November 15, 2012, at 8:55 a.m., in the coordinator's office, confirmed the family was not notified after the resident's fall on November 13, 2012.	F 157	F164 Corrective Action: 1. The CNA was aware of her mistake and apologized to Resident #78. She was also counseled by RCC on the importance of maintaining the dignity of residents when providing care. Completed:	11/15/12
			2) CNA's will be reinserviced by DON, ADON or RCC on the importance of maintaining a residents dignity when bathing and/or providing incontinence care. Complete by:	12/30/12
			Identifying Other Patients: 1. Walking rounds will be conducted by DON, ADON, RCC or SW to identify if any other residents are affected. Complete by:	12/15/12
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal	F 164	Measures & Changes to be taken: 1. All CNA's will be reinserviced by DON, ADON or RCCon the importance of maintaing a residents dignity when providing care.	12/30/12
			Monitoring Performance: 1. The DON, ADON or SW will do a QA Study monthly x 2 on 10+ Residents that will include interviews of residents to ensure their dignity is being protected when patient care is being provided. Results will be reported monthly to the QA Committee consisting of Medical Director or Physician Designee, DON or Designee, ADM or Asst ADM, SW, Dietician and other team members. After initial 2 month monitoring, QA frequency may be reduced depending on results. To be completed by:	12/30/12

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F 164	Continued From page 4 and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to protect privacy during care of one resident (#78) of forty-three residents reviewed. The findings included: Resident #78 was admitted to the facility on August 31, 2012, with diagnoses including Seizure Disorder, Chronic Kidney Disease Stage IV, Dementia, Pressure Ulcer to Sacrum Stage IV, Right Buttock Pressure Ulcer Stage IV and Weight Loss. Observation of resident #78 on November 15, 2012, at 1:31 p.m., in the resident's room, after entering the room during a medication pass, revealed the resident was in bed, lying on the resident's right side with the gown pulled up to the waist and the bed covers pulled down to the ankles. Further observation revealed the incontinent pad was bunched together under the coccyx area, also exposed, the privacy curtains were not drawn, and no staff were present in the room.	F 164	This page intentionally left blank	

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F 164	Continued From page 5 Interview with Licensed Practical Nurse (LPN) #2 on November 15, 2012, at 1:35 p.m., in the hallway directly outside the resident's room, revealed the resident was receiving incontinence care when left uncovered in the room. Interview with Certified Nursing Assistant (CNA) #1 on November 15, 2012, at 1:35 p.m., outside the resident's room, confirmed the resident was left uncovered while the CNA went to assist another resident. When questioned why this was done, the CNA said "There is no excuse. I thought I could get back in time to finish." Further interview with LPN #2 confirmed the facility failed to protect the privacy of the resident during incontinence care.	F 164	F176 Corrective Action: 1. All Licensed Nurses will be reinserviced by DON or ADM to not leave residents unattended during albuterol nebulizer and/or breathing treatments unless they have been assessed to be able to self-administer medications safely. To be completed by: 2. Resident #225 was assessed to safely administer his own breathing treatment with medication. Completed by: Identifying Other Patients: 1. All Residents that receive breathing treatments will be assessed based on a review of their cognitive status by ADON or RCC to determine if they are able to self-administer medications safely. Measures & Changes to be taken: 1. All Licensed Nurses will be reinserviced by DON or ADM to not leave residents unattended during albuterol nebulizer and/or breathing treatments unless they have been successfully assessed to be able to self-administer medications by: Monitoring Performance: 1. The DON or ADON will do a QA Study monthly x 2 on 5+ Residents that will include observation of Residents receiving breathing treatments to ensure Residents are not left unattended during breathing treatments. Results will be reported monthly to the QA Committee consisting of Medical Director or Physician Designee, DON or Designee, ADM or Asst ADM, SW, Dietician and other team members. After initial 2 month monitoring, QA frequency may be reduced depending on results. To be completed by: (See Next Page)	12/30/12 12/15/12 12/30/12 12/30/12 12/30/12
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and interview the facility failed to assure one resident (#225) was assessed for self-administration of a medication of forty- three residents reviewed. The findings included: Resident #225 was admitted to the facility on August 18, 2011, with diagnoses including	F 176		

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F 176	Continued From page 6 Dementia, Benign Prostate Hypertrophy and Chronic Obstructive Pulmonary Disease. Medical record review of a Physician's Recapitulation Order for November 2012, revealed "...Albuterol .5 - 3mg (milligram)...give 1 unit per aerosol 4 times daily..." Observation on November 14, 2012, at 8:27 a.m., in the resident's room, revealed the resident was resting in bed in an isolation room, with the door closed. Continued observation revealed the resident was receiving an albuterol nebulizer treatment with no staff present. Observation revealed the resident's nurse was not in view of the resident. Interview on November 14, 2012, at 8:29 a.m.,on the 400 hallway, with Licensed Practical Nurse (LPN) #1 confirmed the albuterol nebulizer was started and the nurse left the resident unattended. Interview on November 14, 2012, at 9:53 a.m., at the unit 4 nurse's station, with unit manager #1, confirmed the resident had not been assessed for self administration of the albuterol breathing treatment.	F 176	F241 Corrective Action: 1. All CNA's will be inserviced by DON, ADON, RCC or ADM to serve meals of Residents in the same room as close to the same time as possible to maintain or enhance each Residents dignity and respect in full recognition of his or her individuality. To be completed by: Identifying Other Patients: 1. Residents will be observed during meal time by ADM or SW to see if any other Residents are affected by: Measures & Changes to be taken: 1. All CNA's will be Inserviced by DON, ADON, RCC or ADM to serve meals of Residents in the same room as close to the same time as possible to maintain or enhance each Residents dignity and respect in full recognition of his or her individuality. To be completed by: Monitoring Performance: 1. The DON, ADON, RCC or SW will do a QA Study monthly x 2 on 10+ Residents that will include observations during meal time to ensure Residents that are in the same room are served as close to the same time as possible to maintain or enhance each Residents dignity and respect. Results will be reported monthly to the QA Committee consisting of Medical Director or Physician Designee, DON or Designee, ADM or Asst ADM, SW, Dietician and other team members. After initial 2 month monitoring, QA frequency may be reduced depending on results. To be completed by: (See Next Page)	12/30/12 12/20/12 12/30/12 12/30/12
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced	F 241		

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F 241	Continued From page 7 by: Based on observation and interview, the facility failed to provide one resident (#158) a meal tray while the roommate was eating of forty-three residents sampled. The findings included: Observation on November 14, 2012, at 8:50 a.m., in the resident's room, revealed the roommate of resident #158 was self feeding their breakfast. Further observation revealed resident #158 had not received a tray. Further observation revealed resident #158 pressed the call light and the responding Certified Nurse Aide (CNA) #2 asked resident #158 what (resident) needed. Resident #158 pointed to the roommate and questioned the CNA why (resident #158) had not received their tray. Further observation at 9:01 a.m., revealed CNA #2 delivered resident #158's tray and resident #158 proceeded to self feed their breakfast. Interview with CNA #2 on November 14, 2012, at 9:01 a.m., in the residents' room, revealed both residents, #158 and the roommate, breakfast trays were delivered on the same cart. Further interview confirmed both residents were to receive their breakfast at the same time.	F 241	This page intentionally left blank	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced	F 253		12/30/12

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F 253	Continued From page 8 by: Based on observation and interview, the facility failed to maintain three ceiling vents and twelve ceiling tiles in the main dining room in a sanitary manner; failed to maintain resident fans in a sanitary manner for two (#40 and #94) of forty-three residents reviewed; and failed to maintain two soiled linen carts and one clean linen rack in a sanitary manner on the 100 hall. The findings included: Observation on November 13, 2012, at 11:41 a.m., in the main dining room during the mid-day meal service, revealed two ceiling vents and surrounding ceiling tiles, located on either end of the steam table; and one ceiling vent and surrounding ceiling tiles, located closest to the clock and over dining tables, had a heavy black accumulation of debris. Further observation revealed twelve stained ceiling tiles. Interview on November 13, 2012, at 11:43 a.m., with the facility Registered Dietitian, in the main dining room, confirmed three ceiling vents and surrounding ceiling tiles had a heavy accumulation of black debris and twelve ceiling tiles were stained. Observation on 100 hall, outside room 115, on November 14, 2012, at 8:25 a.m., revealed two soiled linen carts with stained exteriors and a heavy accumulation of dust and debris. Further observation revealed a covered clean linen rack containing linen, between the two soiled linen carts, with a heavy accumulation of dust on the frame of the rack.	F 253	F253 Corrective Action: 1. The Dining Room ceiling vents and ceiling tiles were cleaned at the time the surveyor reported their concern. 2. The 2 personal fans of Resident #40 & #94 were removed from the room, cleaned and returned to each Resident at the time the surveyor reported their concern. 3. The 2 soiled linen carts and clean linen rack were cleaned at the time the surveyor reported their concern. Identifying Other Patients: 1. An inspection of all personal fans and ceiling vents will be conducted by HSKP Supr or Maint Supr to ensure they are clean and that no other residents are affected. Measures & Changes to be taken: 1. HSKP staff will be inserviced by HSKP Supr to check and clean ceiling vents, personal fans, clean & soiled linen carts to ensure they are free of dust-buildup or debree. To be completed by: Monitoring Performance: 1. The HSKP Supr or Maint Supr will do a QA Study monthly x 2 on personal fans, ceiling vents, ceiling tiles, clean & soiled linen carts that will include visual inspections to ensure they are free from dust buildup and/or debris. Results will be reported monthly to the QA Committee consisting of Medical Director or Physician Designee, DON or Designee, ADM or Asst ADM, SW, Dietician and other team members. After initial 2 month monitoring, QA frequency may be reduced depending on results. Complete by: (See Next Page)	11/15/12 11/15/12 11/15/12 12/20/12 12/30/12 12/30/12

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F 253	Continued From page 9 Interview on November 14, 2012, at 8:30 a.m., with the Housekeeping Director, outside room 115, confirmed the two soiled linen carts had soiled exteriors and had a heavy accumulation of dust and debris. Further interview confirmed the clean linen rack had a heavy accumulation of dust on the frame of the rack. Observation on November 15, 2012, at 8:22 a.m., of resident #40's fan on the floor at the foot of the bed, revealed the fan grate and blades had a heavy accumulation of dust and debris. Further observation revealed resident #94 in bed with a fan in operation on the bed-side table and pointed directly at the resident. Further observation revealed a heavy accumulation of debris hanging from the fan grate. Interview in the room of residents #40 and #94, on November 15, 2012, at 8:26 a.m., with Licensed Practical Nurse (LPN) #5, confirmed both fans had a heavy accumulation of dust and debris on the grates. Observation revealed LPN #5 turned off resident #94's fan. Further observation revealed resident #94's fan blades were also covered with a heavy accumulation of debris. Further interview with LPN #5 confirmed both resident's fans had blades with a heavy accumulation of dust and debris.	F 253	This page intentionally left blank	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive	F 272		12/30/12

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	445013	A. BUILDING _____ B. WING _____	11/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 272	Continued From page 10 assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to complete the Minimum Data Set (MDS) accurately for one resident (#281) of twenty-nine residents reviewed	F 272	F272 SS=D Corrective Action: 1. Resident #281 was discharged home with home health on 11/14/12. Identifying Other Patients: 1. All residents PASRRs from 9/26/12 to 11/15/12 will be reviewed by DON to ensure any resident with a level 2 PASRR has the mental illness documented on the MDS and Care Plan. To be completed by: Measures & Changes to be taken: 1. MDS Coordinators will be instructed by ADM or DON to review the PASRR for any mental illness diagnosis prior to coding & completing the MDS. To be completed by: 2. Social Workers will be inserviced by ADM to submit any medical record documentation received from a family member to Health Information to be implemented into the medical record according to facility policy. Complete by: Monitoring Performance: 1. The DON or ADON will do a QA Study monthly x 2 on new admissions PASRRs from 11/16/12 forward to ensure mental illness diagnosis and/or behaviors are identified. Results will be reported monthly to the QA Committee consisting of Medical Director or Physician Designee, DON or Designee, ADM or Asst ADM, SW, Dietitian and other team members. After initial 2 month monitoring, QA frequency may be reduced depending on results. To be completed by: (See next page)	12/20/12 12/20/12 12/20/12 12/30/12

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F 272	Continued From page 11 of forty-three residents sampled. The findings included: Resident #281 was admitted to the facility on September 26, 2012, with diagnoses including Sternal Wound Dehiscence, Diabetes Mellitus Type II, Bipolar, and Chronic Obstructive Pulmonary Disease. Medical record review of the admission MDS dated October 24, 2012, revealed no behavior issues addressed and no diagnosis of Bipolar. Medical record review of the Pre-Admission Screening and Resident Review (PASRR) dated September 26, 2012, revealed "...Mental Illness: Yes...diagnosis: Bipolar..." Medical record review of a Social Service Note dated October 4, 2012, revealed "...Pt (patient) very guarded and suspicious...Pt very abrupt...Pt cursed...PT refused assess (assessment)...pt has been uncooperative/cursing at other staff as well..." Medical record review of a Social Service Note dated October 23, 2012; revealed "...Pt's sister...brought in documentation dated 6/25/11...eval'd (evaluated) by a psyc (psychiatrist) diag (diagnosis) Schizoaffective...Bipolar Type...Borderline Personality D/O (disorder)...signed (named psychiatric service) Consult..." Interview with the Director of Nursing (DON) on November 14, 2012, at 4:30 p.m., in the DON office, confirmed the MDS was not accurate.	F 272	This page intentionally left blank	

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F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to evaluate and update the care plan for one resident (#21) for behaviors, and for one resident (#40) for dental needs of twenty-nine residents reviewed of forty-three residents sampled. The findings included: Resident #21 was admitted to the facility on May 23, 2012, with diagnoses including Dementia without Behaviors, Hospice, Anxiety, and End	F 280	F280 SS=D Corrective Action: 1. Resident #21 passed away on 11/23/12. We will not correct her care plan at this time to reflect the residents behaviors and use of Haldol as identified. To be completed by: 2. Resident #40 has been provided denture adhesive to use as needed. The care plan has been updated. Identifying Other Patients: 1. All residents receiving Haldol will be reviewed by DON or ADON to ensure their care plan reflects a reason for its use. To be completed by: 2. All residents with dentures that are using denture adhesive will be identified by ADON. Records will be reviewed to ensure denture adhesive is care planned for residents use. Complete by: Measures & Changes to be taken: 1. RCC's will be inserviced by DON or ADON to update the care plan when needed to reflect new information, recommendations, behavior changes and/or interventions. Completed by: Monitoring Performance: 1. The DON or ADON will do a QA Study monthly x 2 on residents receiving Haldol to ensure behaviors and interventions are documented on the care plan. The DON or ADON will also do a QA monitor monthly x 2 to check residents with dentures where adhesive is recommended to ensure it is care planned for use. Results will be reported monthly to the QA Committee consisting of Medical Director or Physician Designee, DON or Designee, ADM or Asst ADM, SW, Dietician and other team members. After initial 2 month monitoring, QA frequency may be reduced depending on results. Complete by: (see next page)	11/30/12 12/20/12 12/30/12 12/30/12 12/30/12 12/30/12

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F 280	Continued From page 13 Stage Renal Disease. Medical record review of a quarterly Minimum Data Set (MDS) dated August 21, 2012, revealed memory impairment, no behaviors, and required extensive assistance with all Activities of Daily Living (ADL's.) Medical record review of a care plan dated August 30, 2012, revealed no care plan for behaviors and the use of Haldol. Medical record review of a Nurse's Note dated September 11, 2012, revealed "...can become combative with care..." Medical record review of a Nurse's Note dated September 25, 2012, revealed "...increased agitation noted..." Medical record review of the Physician's Recapitulation orders dated November 1, 2012, through February 1, 2013, revealed "...Haloperidol 1mg (milligram) SQ (subcutaneous) every morning at 6:30 a.m. or PO (per mouth)..." Observation on November 14, 2012, at 8:30 a.m., in the resident's room, revealed the resident lying on the bed. Interview with Unit Manager #1 on November 11, 2012, at 9:42 a.m., at the Nurse's Station, revealed the Haldol was given subcutaneously, the resident refuses to take medications orally, refuses care, and becomes combative with personal care.	F 280	This page intentionally left blank	

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F 280	Continued From page 14 Interview with the Director of Nursing (DON) on November 15, 2012, at 10:00 a.m., at the Nurses Station, revealed the care plan had not been updated to reflect the resident's behaviors and the use of Haldol. Resident #40 was admitted to the facility on November 22, 2011, with diagnoses including Chronic Obstructive Pulmonary Disease, Diabetes Mellitus, Late Effect Cerebrovascular Accident with Left Side Weakness, and Hypertension. Medical record review of the annual Minimum Data Set dated October 22, 2012, revealed the resident scored a fourteen out of fifteen for cognition; had broken or loosely fitting full or partial denture; and had no mouth or facial pain, discomfort or difficulty with chewing. Medical record review of the Dental Progress Notes revealed: "October 12, 2012, Exam: Periodic Oral Evaluation, Consultation; Other procedures: Can not wear new dentures, No ridge; October 19, 2012, alignment impression made for a new lower complete denture with a permanent cushion liner; October 23, 2012, Wax bite registration; and October 30, 2012, Delivery of new lower complete denture w (with) a permanent cushion liner. Attending nurse and administrator informed." Medical record review of the Social Services Progress Note dated October 31, 2012, revealed "...Got (resident) new dentures yesterday. (Resident) is real excited and says they fit good..."	F 280	This page intentionally left blank	

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F 280	Continued From page 15 Medical record review of a physician phone order dated November 13, 2012, revealed "Dental Consult loose fitting dentures." Medical record review of the nurse's note dated November 13, 2012, revealed "...Spoke w (named dentist) and informed him that (Resident) was c/o (complaining of) loose fitting dentures. (Named dentist) informed writer that only thing you can do is have (resident) to apply adhesive to (resident's) dentures. There is nothing else I can do to the dentures to adjust them. Writer stated OK..." Medical record review of the care plan dated October 30, 2012, revealed no documentation of the use of adhesive. Interview with Certified Nurse Aide #3, working the 3:00 p.m. to 11:00 p.m. shift, on November 14, 2012, at 4:21 p.m., at the station one nursing station, confirmed resident #40 "...has false teeth, at night take them out and place (false teeth) in cup...(resident) does not use adhesives..." Interview with Certified Nurse Aide #4 on November 15, 2012, at 8:39 a.m., at the station one nursing station, confirmed the resident "... has dentures...does not need adhesive and if (resident) needed adhesive I would apply it..." Interview with Unit Manager #3 on November 15, 2012, at 9:20 a.m., at the station one nursing station, confirmed the nurse failed to update the care plan to address the use of a dental adhesive.	F 280	This page intentionally left blank	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		12/30/12

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F 371	Continued From page 16 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility dietary department failed to maintain the walk-in refrigerator condenser grates, ceiling area in front of the condenser unit, and the ceiling vents and surround ceiling tiles in the dietary department in a sanitary manner. The findings included: Observation on November 13, 2012, at 11:27 a.m., with the facility Registered Dietitian present, revealed the walk-in refrigerator condenser grates and ceiling area in front of the condenser had a heavy accumulation of debris present. Interview with the Registered Dietitian, present during the observation on November 13, 2012, at 11:27 a.m., confirmed the walk-in refrigerator condenser grates and ceiling area in front of the condenser had a heavy accumulation of debris present. Observation on November 15, 2012, beginning at 7:45 a.m., with the regional representative	F 371	F 371 SS=F Corrective Action: 1. The walk-in refrigerator condenser grates had some dust on them and have been cleaned. All prepared food was covered and not exposed to the dust identified. 2. All vents and ceiling tiles identifed were throughly cleaned after identification by surveyor that same day. Identifying Other Patients: 1. No patients were identified as being affected by this deficiency. All food, food preperation areas and equipment were found to be clean during the survey. Measures & Changes to be taken: 1. All Dietary & Maintenance Staff will be inserviced by ADM or RD on the importance of cleaning vents, fans and ceiling tiles in the Kitchen and Dining Rooms. To be completed by: Monitoring Performance: 1. ADM, RD or Maint Supr will use a QA monitor that will be developed to check all vents, fans and ceiling tiles in the Kitchen and Dining Rooms for cleanliness. The QA monitor all vents, fans, and ceiling tiles in the Kitchen and Dining Rooms each month for 3 months with results reported to the QA Committee consisting of Medical Director or Physician Designee, DON or Designee, ADM or Asst ADM, SW, Dietician and other team members. After initial 3 month monitoring, QA frequency may be reduced depending on results. To be completed by: (See next page)	11/15/12 11/15/12 12/15/12 12/30/12

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F 371	Continued From page 17 present, of the resident morning meal tray line service in the dietary department, revealed a ceiling vent and surrounding ceiling tiles located above the steam table service area, were covered with a heavy accumulation of debris. Further observation revealed a ceiling vent and surrounding ceiling tiles in the area between the steam jacketed kettle and the tray line were covered with a heavy accumulation of debris. Interview on November 15, 2012, at 8:10 a.m., in the dietary department by the steam table, with the facility regional representative, confirmed the ceiling vents and surrounding ceiling tiles over the steam table service area and between the steam jacketed kettle and steam table had heavy accumulations of debris.	F 371	This page intentionally left blank	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to notify the physician timely of pharmacy consultant reports for one resident (#225) of forty-three residents reviewed.	F 428		

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F 428	Continued From page 18 The findings included: Resident #225 was admitted to the facility on August 18, 2011, with diagnoses including Dementia, Benign Prostate Hypertrophy and Chronic Obstructive Pulmonary Disease. Medical record review of a Consultant Pharmacist's Recommendation dated August 9, 2012, revealed "...Sulfasalazine (drug used for ulcerative colitis)...consider decreasing dose to 1 gm (gram) in the morning and 500 mg (milligram) in the evening..." Continued review of the recommendation revealed the Physician/ Prescriber response was not addressed until August 21, 2012 (12 days after recommendation). Interview with Unit Manager #1 on November 14, 2012, at 4:05 p.m., at the station 4 nurse's station, confirmed the facility failed to act upon the pharmacy consultant reports timely.	F 428	F 428 SS=D Corrective Action: 1. The Physician saw Resident #225 on 8/7/12. The Pharmacist Recommendation dated 8/9/12 was acted upon 8/21/12 within 12 days. Action was taken within the 30 day timeframe of the next required Physicians visit. There are no specific guidelines defining what a timely response is. This recommendation did not have a potential for serious harm. 2. RCC's will be reinserviced by DON on the importance of communicating Pharmacist recommendations to the Physician or their designee timely by: Identifying Other Patients: 1. All Pharmacist recommendations from 11/13/12 to 11/15/12 will be reviewed by DON or ADON to ensure no other patients were affected. To be completed by: Measures & Changes to be taken: 1. RCC's will be reinserviced by DON on the importance of communicating Pharmacist recommendations to the Physician or their designee timely by: Monitoring Performance: 1. DON or ADON will use a QA monitor that will be developed to check a sample of 5+ Pharmacist recommendations to ensure they are communicated timely to the Physician or their designee. The QA monitor will be each month for 2 months with results reported to the QA Committee consisting of Medical Director or Physician Designee, DON or Designee, ADM or Asst ADM, SW, Dietician and other team members. After initial 2 month monitoring, QA frequency may be reduced depending on results. To be completed by:	11/15/12 12/30/12 12/20/12 12/30/12 12/30/12
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441		

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F 441	Continued From page 19 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and interview, the facility failed to follow infection control practices during medication administration for one resident (#281) of ten medication administrations observed and failed to assure that the biohazard trash was secure on one of four stations. The findings included: Observation on November 13, 2012, at 7:45 a.m., revealed Licensed Practical Nurse (LPN) #4	F 441	This page intentionally left blank	

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F 441	Continued From page 20 prepared resident #281's medication, entered the resident's room, placed the inhaler chamber on the resident's bedside table, and the resident self administered the inhaler. Further observation at this time revealed LPN #4 placed the inhaler chamber on the bathroom sink, washed the hands, exited the room, placed the inhaler chamber on the medication cart, unlocked the medication cart, and placed the inhaler chamber in the medication cart. Interview with LPN #4 on November 13, 2012, at 7:50 a.m., on the 300 hallway, confirmed infection control practice was not followed during medication administration. Observation on November 13, 2012, at 11:38 a.m., across from the station 3 nurse's station, revealed a housekeeping door was left unlocked leading to a biohazard trash closet, also left unlocked. Continued observation revealed multiple isolation boxes half full and a visible sharps container. Observation and interview on November 13, 2012, at 11:40 a.m., with the Director of Nursing, confirmed the doors were to be locked and secured.	F 441	F 441 SS=D Corrective Action: 1. Nurses will be inserved by DON or ADM on infection control practices when administering medications. Complete by: 2. The closer for the Bio-Hazard door has been inspected and repaired. A lock will also be added to the exterior door. To be completed by: 3. Resident #281 was discharged home with Home Health on 11/14/12 with no known no negative outcome from this incident. Identifying Other Patients: 1. The DON, ADON or RCC will observe Nurses dispensing medications to ensure no other residents are affected by failing to follow infection control practices during medication administration by: Measures & Changes to be taken: 1. Licensed Nurses will be inserviced by DON or ADM on the importance of infection control practices when dispensing medications. To be completed by: 2) All Bio-Hazard doors will be inspected by Maint Supr to ensure closers and locking mechanisms are working properly by: Monitoring Performance: 1. Maint Supr or ADM will use a QA monitor that will be developed to check Housekeeping & Bio-Hazard doors are secured properly. DON or ADON will use a QA monitor that will be developed to observe the medication pass for infection control practices. The QA monitors will be each month for 2 months with results reported to the QA Committee consisting of Medical Director or Physician Designee, DON or Designee, ADM or Asst ADM, SW, Dietician and other team members. After initial 2 month monitoring, QA frequency may be reduced depending on results. To be completed by: (see next page)	12/20/12 12/5/12 12/20/12 12/30/12 12/20/12 12/20/12 12/30/12
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced	F 463		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445013	A. BUILDING _____ B. WING _____	11/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, CHATTANOOGA	2700 PARKWOOD AVE CHATTANOOGA, TN 37404

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F 463	Continued From page 21 by: Based on observation and interview, the facility failed to have operational call lights in two of two whirlpool rooms. The findings included: Observation on November 15, 2012, beginning at 1:00 p.m., with the Maintenance Director present, revealed the call lights were not working in the whirlpool rooms located on station 3 and station 4. Interview with the Maintenance Director present during the observation on November 15, 2012, beginning at 1:00 p.m., confirmed the call lights were not working in stations 3 and 4. Further interview confirmed the residents did use the whirlpool rooms.	F 463	F 463 SS=D Corrective Action: 1. Call lights will be repaired and/or installed in both whirlpool rooms identified. Identifying Other Patients: 1. No residents were affected. All patient rooms and patient bathrooms have working call lights. Measures & Changes to be taken: 1. Residents use showers in their rooms. These additional whirlpool rooms will be taken out of use and secured until call lights are installed and operable. Monitoring Performance: 1. Maint Supr or ADM will use a QA monitor that will be developed to check call lights in both whirlpool rooms are in place and working properly. The QA monitor will be each month for 2 months with results reported to the QA Committee consisting of Medical Director or Physician Designee, DON or Designee, ADM or Asst ADM, SW, Dietician and other team members. After initial 2 month monitoring, QA frequency may be reduced depending on results. To be completed by: (See Next Page)	12/30/12 12/30/12 12/30/12
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require	F 520		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 520	Continued From page 22 disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of Quality Committee sign in sheets, Quaility Committee member list, and interview, the facility failed to maintain a quality assessment committee that met at least quarterly. The findings included: Review of sign in sheets with Assistant Director of Nursing (ADON) #1 on November 15, 2012, at 1:00 p.m., in the ADON office on station three, revealed the physician designated by the facility had only attended two meetings from October 2011 to October 2012. Interview with ADON #1 on November 15, 2012, at 1:10 p.m., in the ADON office at station three, revealed the designated physician had been informed about the requirement to attend meetings at least quarterly. Further interview confirmed "the physician was on the committee but not an active participant," and had not attended the Quality Assurance meetings at least quarterly.	F 520	F 520 SS=D Corrective Action: 1. The Medical Director and/or his Physician Designee attended September 2012 and October 2012 Quality Assurance Meetings. They have been notified to attend the Quality Assurance Committee Meetings no less than Quarterly as required. Identifying Other Patients: 1. No residents were affected. Measures & Changes to be taken: 1. The Medical Director and/or his Physician Designee will attend the Quality Assurance Committee Meetings Quarterly as required. Monitoring Performance: 1. DON or ADON will use a QA monitor that will be developed to check attendance of Medical Director or their Physician Designee at the Quality Assurance Committee meetings each quarter. The QA monitor will be each quarter for 4 quarters with results reported to the QA Committee consisting of Medical Director or Physician Designee, DON or Designee, ADM or Asst ADM, SW, Dietician and other team members. After initial 4 quarters of monitoring, QA frequency may be reduced depending on results. To be completed by: (See Next Page)	12/20/12 12/30/12 12/30/12